MENTAL HEALTH SERVICES OF CATAWBA COUNTY
SERVING BURKE & CATAWBA COUNTIES

Service Authorization Request Form

Date Type of Request ☐ Agency Change ☐ Continuing ☐ Decrease ☐ Increase ☐ New ☐ Transfer ☐ Termination

Provider: Contact Name:

Fax #: Call Back #: E-mail:

DSS is Guardian? ☐ Yes ☐ No DJJ will pay? ☐ Yes ☐ No MH Pays Room & Board Only? ☐ Yes ☐ No

Is the request for residential services for a child with private insurance? ☐ Yes ☐ No (Attach insurance denial letter.)

Services to be authorized: Number of Months? ☐ 1 ☐ 2 ☐ 3 ☐ Request for entire date range ☐ Request for monthly date range

Service Code	Start Date	End Date	# Units/Hours/Days	Funding Source

Please list the credentials of the person providing the service for rate and billing purposes:

Consumer: MR#: DOB:
County of Residence:
Effective Date of Current PCP: Submitted to LME? ☐ Yes ☐ No
Tx Team Meeting Date: Attendees/Recommendations:

Target Population(s): AMCS ☐ AMSPM ☐ AMSMI ☐ AMPAT ☐ AMDEF ☐ AMSRE ☐ ASCDR ☐ ASCJO ☐ ASDSS ☐ ASDWI ☐ ASHMT ☐ ASWOM ☐ ASDHH ☐ ASHOM ☐ ADCS ☐ ADSN ☐ ADMRI ☐ CMCS ☐ CMECD ☐ CMSED ☐ CMMED ☐ CMDEF ☐ CMPAT ☐ CSMAJ ☐ CSSAD ☐ CSIP ☐ CSSP ☐ CSWOM ☐ CSCJO ☐ CSDWI ☐ CSCS ☐ CDSN

Diagnoses: ☐ See Attached Plan
AXIS I -
AXIS II -
AXIS III -
AXIS IV -

Medications	Dosage & Route	Schedule	Medication Compliant?	Target Symptoms
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Current GAF Score (on last face to face visit):

NC-SNAP (DD consumers only) Composite Score:

For LME Use ONLY:
Days & Specific Hours/Units Authorized Restrictions (i.e. # hours/units/days/weeks/months):

Clinical Authorization: Date:

Notes:

- *The provider claims responsibility for current and on-going verification of funding source and eligibility.*
- *Authorization does not guarantee payment in the event that eligibility or funding source changes.*
- *Re-authorization supercedes previous authorization.*

MENTAL HEALTH SERVICES OF CATAWBA COUNTY
SERVING BURKE & CATAWBA COUNTIES

MR #: Consumer Name: Date:

ASAM Level:

ASAM Risk Rating for Substance Abuse (if applicable)
A higher risk rating indicated greater level of severity and/or intensity.

1. Withdrawal/Intoxication ☐ Lo ☐ Med ☐ Hi
2. Medical Conditions ☐ Lo ☐ Med ☐ Hi
3. Behavioral/Emotional/Cognitive Conditions ☐ Lo ☐ Med ☐ Hi
4. Readiness for Change (Low Readiness = High Risk) ☐ Lo ☐ Med ☐ Hi
5. Relapse/Continued Use or Problem Potential ☐ Lo ☐ Med ☐ Hi
6. Recovery Environment ☐ Lo ☐ Med ☐ Hi

Clinical Risk Assessment:
Risk to Self (SI): ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Assessed for hospitalization ☐ Prior attempt, date:
Risk to Others (HI): ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Assessed for hospitalization ☐ Prior attempt, date:

Recent Abuse/Neglect/Exploitation: ☐ Yes ☐ No If yes, please describe event(s) & impact:

Natural/Community Supports: Please check all strengths/supports that are in place for this consumer:
☐ Consumer's family/supports involvement in treatment ☐ Care has been coordinated with other behavioral health providers.
☐ Care has been coordinated with other medical providers. ☐ A psychiatrist has evaluated the consumer.
☐ Child Protection ☐ Legal System ☐ Employer ☐ Other:
List specific conditions of cours/DSS, if required to be addressed in treatment (include any commitment orders:

Since last authorization, rate the use of natural supports: ☐ new service request ☐ no change ☐ significantly increased ☐ significantly decreased ☐ somewhat increased ☐ somewhat decreased

Since last authorization, rate overall functioning: ☐ new service request ☐ no change ☐ significantly increased ☐ significantly decreased ☐ somewhat increased ☐ somewhat decreased

Clinical Summary: (Include progress since last authorization. Explain clinical outcomes that support medical necessity for continuation, increase or reduction in services.

Expected Results/Outcomes from Treatment: ☐ Hold job ☐ Symptom Free ☐ Manages Meds/Med Compliant ☐ Abstinent ☐ Function Independently/ADL's Satisfactory ☐ Public School Setting ☐ Return to Home ☐ Independent Living ☐ Resolve Legal Issues ☐ Other

Discharge/Transition Plan: ☐ Barriers to discharge ☐ Discharge treatment setting not available ☐ Transportation ☐ Legal Matter ☐ Adequate housing/residence ☐ Community supports not fully developed ☐ Treatment non-compliance ☐ Other
Describe plan to move to a less intensive level of care/services: